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ABSTRACT

Affective disorder is characterized by maladaptive changes in mood, attitudes, energy level, and physical status. These changes constitute the basic dimensions of depression. Depression results from a combination of genetic and experiential factors. There are sex differences and age differences with regard to depression, and there is a high correlation of depression between mothers and their children. Cognitive, learned helplessness, and behavioral theories have been proposed to explain the role of loss in depression. The role of loss in causing depression helps to account for the rapid increase in the frequency of affective disorders throughout adolescence. The normal developmental process presents teenagers with many real losses and threats to their sense of adequacy. Younger adolescents rarely display traditional adult symptoms of depression. Depressed adolescents may have problem behavior which they act out through temper tantrums, running away, stealing, truancy, and other rebellious or antisocial acts. By the age of 15 or 16, adolescents may exhibit depression through drug abuse, sexual promiscuity, alienation, or suicidal behavior. Studies show that children do not outgrow depression. Three forms of treatment are commonly used to treat depressed adolescents: psychotherapy, environmental manipulation, and drug therapy. Although only about five percent of all adolescents are diagnosed as depressed, the incidence of depression in adolescence probably greatly exceeds this level. (NB)

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ADOLESCENT DEPRESSION

by

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Affective disorder is characterized by maladaptive changes in a person's mood, attitudes, energy level, and physical status. It occurs in two specific types. One type is unipolar affective disorder which manifests itself in episodes of depression. The other type is bipolar affective disorder. Bipolar involves episodes of mania or sometimes both mania and depression.

Mania is characterized by tireless good spirits, enormous energy, unbounded optimism, enthusiasm, and a strong sense of well being. Feeling happy is a normal reaction when one's life takes a turn for the better. When an especially happy event occurs, it may produce a period of elation, just as an especially sad event causes moments of grief. When elation continues out of proportion to the actual event, it constitutes a pathological manic reaction. Mania usually occurs in people who suffer depressive episodes. This type of person is commonly referred to as a manic depressive.

Depression falls on the opposite emotional pole as mania. It is the most common psychiatric disorder. Most people have experienced this familiar psychological state in response to diappointment and frustration like the breakup of a close personal relationship or failing to acheive a desired goal. Such events leave people feeling sad, discouraged or apathetic. Especially distressing experiences, such as death of a close friend, may cause temporarily disabing depression which is usually referred to as grief. Grief is a normal reaction,so long as it does not persist for an unusually long period of time. When episodes of depression become more profound or last longer than the event would seem to justify, they constitute a pathological depressive reaction or a unipolar affective

disorder.

There are many factors involved when studying the depressive vulnerability of people. Evidence is becoming available that a small percentage of individuals (10-15%) may be at a high risk for the development of clinical depression at sometime during childhood, adolesence, or adult life. Quite early in a toddler's life, a cluster of responses begin to emerge suggestive of a basic depressive mood. It includes a tendency to moodiness, self centeredness, hypersensitivity to small losses or frustrations, withdrawing behavior in the face of any difficulty, and the need for clinging and demanding relationships characterized by a high degree of ambivalence. When these traits become associated with inadequate mothering, early spoiling followed by later rejection, promises made and not kept, and frequent separations for which the child is ill prepared, the probability for future clinical depression becomes almost predictable.[1]

There are definite sex differences with regards to depression. From at least ten years of age, females are more likely to be diagnosed depressed than males. This sex difference increases gradually during the adolescent years and by adulthood, depression is more than twice as frequent among females than among males. The greater chances of females becoming depressed seems to involve biological as well as experiences of sex role limitations. Although not as prevalent as once was the case, there are elements of the traditional female role in our society. The low social status and discrimination in achievement-related situations account, in part, for the greater episodes of depression among women than among men.

Just as there are sex differences, there are also age

differences in regards to depression. The prevalence of diagnosed depression varies considerably with age. Less than one percent of children under ten years old are diagnosed depressed. The rate of depression for both sexes almost doubles between the ages of ten and fourteen (1.7%) and fifteen to seventeen (3.3%). It more than doubles again among eighteen to nineteen-year-olds (7.6%). These eighteen to nineteen year old patients are only half as likely to be diagnosed depressed as twenty-five to forty-four year old patients.[2]

There is a high correlation of depression between mothers and their children. Evidence shows that one-third of the mothers of children referred to guidance clinics were depressed. In a study of psychiatric patients, it was found that the greatest disturbance in the relations of patients were those with affective disorders. Of the patients' children, eighty percent were judged to have psychiatric problems and thirty-four percent were regarded as seriously disturbed.[3] This shows the significance of a mother's behavior on her children.

Depression results from a combination of genetic and experiential factors. Affective disorder runs in families and life events influence individual susceptibility to it and brings on its expression in episodes of depression. In a study of the family histories of thirty-three depressed outpatient adolescents and twenty-five nondepressed psychiatric outpatient adolescents showed that the families of the depressed patients had more affective disorders. The study also found that this was especially so among families of the twenty-three female depressed patients.[4] The more closely two people are related, the more likely they are to share the same condition of affective disorder

or depression. Most significantly, with regard to genetic factors, identical twins show a sixty-nine point two percent average concordance for affective disorder in various studies, whereas non-identical twins show just a thirteen point three percent concordance.[5] Further evidence also lends to the role of genetic factors. It was found, by studying individuals who had been placed for adoption after birth, that three out of eight (37.5%) biological children of mothers with affective disorders had become affectively disordered themselves, compared to only eight out of one-hundred and eighteen (7%) of adopted away children of non-disturbed mothers.

While genetic factors play a major role in depression, experiential factors also contribute. Experiences that often bring on depression include damage to objects one holds dear, failure to achieve some desired goal, and loss of bodily integrity related to illness, physical handicap, disfigurement, or normal biological changes. However, the primary reason for the emergence of depressive disorder is in response to the experience of loss. Depression in response to loss is most apparent when a loved one dies, moves away or rejects a person's affections, leaving him or her to mourn the lost relatinship.

The sense of loss that causes a person to become depressed may be either real or fantasied. A real loss is an actual event that deprives people of something important to them. For example, among adolescents, rejection by a boyfriend, finishing last in a race, or having to wear braces can deprive a youngster of a valued personal relationship, a highly desired success, or a gratifying sense of bodily integrity. A fantasied loss is an

unrealistic concern that causes people to feel deprived in the abscence of any apparent basis. Feelings of being rejected, having failed,or becoming unattractive, arising without solid basis in fact, are among the common fantasied losses that contribute to depression.

The distinction between real and fantasied losses leads to a basis for distinguishing between reactive and endogenous depressions. Real losses tend to lead to reactive depressions in which the depressing circumstances are readily identifiable. It is a self-limiting condition that heals with the passage of time and the replacement of lost objects and goals with new ones. Fantasied depression is likely to be an endogenous depression, in which the origins of the distress are often not apparent to the depressed person. It is a chronic and lingering condition in which professional help is especially likely to be necessary to help the person to unravel and take a more realistic view of the concerns that are depressing him or her.

Aside from genetic or experiential factors that may affect a person's disposition for becoming depressed, individual variations to loss appears to be due to certain kinds of developmental experiences. There are three theories which help to explain the role of loss in depression. They are the cognitive model, the learned helplessness model, and the behavioral model. These theories are not mutually exclusive, but each one can be formulated in terms of the other.

The cognitive model was developed by A. T. Beck. In this model, negative thoughts and attitudes are seen as the core features of depression. Beck acknowledges that a sense of loss is the key event in people becoming depressed but he believes that loss consists of coming to regard oneself as lacking some attributes that

are considered necessary for being happy. He concludes that people become depression-prone when they have encountered unfavorable life situations that have disposed them to overreact to being deprived.

The second theory which helps to explain the role of loss in depression was formulated by M. Seligman. He explains loss in terms of learned helplessness. Learned helplessness consists of the belief that one's actions have little impact on one's own destiny. Children who learn helplessness as a way of viewing the world tend to attribute disappointment and failure to factors beyond their control, such as behavior of others or their own lack of ability. Youngsters who grow into late childhood and adolescence believing that they have little control over their circumstances are inclined to respond to problem situations by feeling unable to cope and becoming depressed.

The last theory was established by P. Lewinsohn. According to hisbehavioral model, depression represents the inability of a person to behave in ways that result in positive reinforcement. People become disposed to depression when their developmental experiences provide them insufficient opportunity to learn gratifying ways of responding to people and events.

The role of loss in causing depression also helps to account for the rapid increase in the frequency of diorder throughout adolescence. The normal developmental process presents teenagers with many real losses and threats to their sense of adequacy. Dramatic bodily changes disrupt their sense of knowing themselves and cause doubts about their physical attractiveness. Societal expectations require them to loosen parental ties and form new kinds of peer and heterosexual relationships. They begin to take

on the major responsiblity for running their lives and planning their futures. Although most adolescents welcome the new rights that maturity brings, few can escape some reservations about giving up the protected position of their childhood and placing their self esteem on the line in new social achievement related situations. Therefore, adolescence increases a persons susceptibility to becoming depressed.

Affective disorder is identified as maladaptive change in mood, attitudes, energy levels, and physical status. These constitute the basic dimensions of depression. Pathologically depressed moods typically involve feelings of sadness, periods of tearfulness and crying, loss of interest in people and previosly enjoyed pursuits, and a diminished ability to experience pleasure. Depressed people withdraw into themselves emotionally. They are difficult, if not impossible, to cheer up and have a dampening affect on those around them.

The attitudes of depressed people are very negative. They tend to have a poor opinion of themselves and a sense of helplessness. They view themselves as inadequate, unattractive, unlovable individuals who are incapable of improving their situations in life. They also may feel a sense of guilt for having behaved improperly. Their low self esteem and self depreciation lead to a degree of pessimisim and hopelessness that often discourages them from even trying to escape their unhappiness.

Depression robs people of their mental and physical energy and leaves them lethargic and unable to concentrate. They tend to move slowly and think slowly, this is sometimes referred to as psychomotor retardation. During such episodes of depression, people have difficulty accomplishing anything because they can't

get their bodies to move or their minds to focus on a task.

A depressed person's physical status is also altered. There are often changes in sleeping patterns, appetite and physical well being. They tend to fall asleep slowly, sleep poorly and wake up easily. After long hours of sleep they are still likely to wake up feeling fatigued and unrefreshed. A person's appetite either becomes much smaller or much larger than usual. Consiquently there tend to lose or gain a great deal of weight. They may fluctuate between periods of total didinterest in eating which is a condition known as anorexia and excessive, insatiable needs to consume food, a condition known as bulimia.

Depression is also reflected in a general sense of feeling poorly physically and an exaggerated concern with health and bodily functions. This is a condition known as hypochondriasis. Depressed people frequently regard themselves as being in poorer physical shape than they used to be and are in fact likely to experience an unusual number of aches, pains, and other somatic complaints that add to their worries about deteriorating health. Some of the somatic symptoms associated with depression are anxiety, fatigre, dizziness, and gastrointestinal disturbances. Pain symptoms are also prominent in depressives and occur in a wide variety of anatomic locations, such as the head, chest, abdomen, and extremities.[6] A study was taken of the common symptoms in adolescents with affective disorder. According to the study, ninety-four percent reported feeling dejected, seventy-four percent reported feeling a loss of interest, sixty-six percent reported feelings of hopelessness, sixty-four percent reported feelings of worthlessness, eighty-four percent reported

impaired concentration, sixty percent reported a loss of energy, and fifty-seven percent reported weight gain or loss.[7]

Younger adolescents rarely display the traditional adult symptoms of depression. They tend to express depression through various types of overt behavior, rather than through introspective preoccupations that typify the depressive symptoms of adults.[8] They are relatively unlikely to display gloom, self depreciation and hopelessness. A young adolescent will often express depression through restlessness, flight to or from people, and problem behavior.

Younger adolescents are so intent on avoiding depressive feelings that they sometimes become more rather than less active in the face of depression. This increased energy seldom accomplishes anything. Youngsters are restless and easily bored. They have a constant need for stimulation and excitement. New pursuits are welcomed with enthusiasum but are dropped as soon as familiarity sets in. Routines of any kind cannot be tolerated and there is a craving for novelty and adventure.

There is also a tendency of flight to or from people. As one aspect of their need for stimulation, depressed adolescents frequently dread being alone and seek constant companionship. There is also a search for more new and interesting friends. In some instances, however, when being around others exposes them to fears of being criticized or rejected, depressed people prefer being alone, rather than with others. They may become intensely involved in solitary pursuits.

Depressed adolescents may have problem behavior which they act out through temper tantrums, running away, stealing, truancy, and other defiant, rebellious, or antisocial acts. To an extent

such problem behavior is novel and exciting. It meets the need of youngsters for stimulation and it helps by avoiding coming to grips with the cause of depression. Public display of strength, bravery, or cunning can impress peers and bolster self esteem. Most importantly, problembehavior compels the attention of the important people in the youngsters life. This provides an indirect way to let those significant others know that he or she is struggling with depressing concerns that cannot be directly expressed. A few studies indicate that over fifty percent of the hospitalizations for "serious, antisocial delinquent behavior with psychotic behavioral episodes have, severe depression."[9]

Some writers refer to these and other efforts to ward off depression as "masked depression." Sometimes this concept is even applied to any manifestations of depression other than changes in mood and self attitudes, including difficulty concentrating, hypochondriasis, loss of appetite, and certain physical complaints. This concept has often proved helpful in the past in identifying disturbed youngsters who could be treated most effectively by focusing on underlying depressive concerns that were not immediately apparent from their presenting symptoms.

As they mature, adolescents become more capable than before of thinking about themselves critically and sharing these thoughts with others. Yet they may still express their depression in maladaptive behavior. The most important behavioral indices of underlying depression that begin to emerge at fifteen or sixteen years of age are drug abuse, sexual promiscuity, alienation, and suicidal behavior.

The persistent, regular use of drugs is uncommon among teenagers and usually reflects serious maladjustment when it occurs. The more frequently they are to do poorly in school, to be

uninvolved in either academic or extracirricular school activities, and to lack any meaningful commitment to social, occupational, or athletic goals. Although drug abuse has multiple causes, its association with these signs of low interest and energy levels identifies the role that depression may play in it. The intoxicating effects of drugs can offer escape from depressing concerns. Illegally obtaining and using drugs can satisfy needs for stimulation and excitement, and sharing drugs with others can provide a sinse of companionship and a hedge against loneliness. Studies show that adolescents who had more behaviors adverse to their health were more depressed. Adolescents who smoked were more frequently depressed than those who did not. Similarly, those who used drugs other than marijuana were depressed more frequently than those who did not.[10]

Sexual promiscuity, like drug abuse, is sometimes regarded as a common feature of contemporary adolescent behavior. Casual, indiscriminant sexuality is rare among young people, especially girls, and it is typically associated with psychological maladjustment when it occurs. Although adolescent girls are less sexually active than boys, they are more likely to use promiscuity as a defense against depression. The reason for this sex difference is that, in sexual encounters, more demands are ordinarily placed on the male than on the female to be knowledgeable and perform will. Since most teenage boys are relatively inexperienced and uncertain of their ability to perform, sexual activity is a risky way for them to try to bolster their feelings of adequacy. The possibility of embarrassment or failure could end up making them feel worse instead of better about themselves. For girls, on the other hand, being promiscuous requires only willingness. They don't have to worry about performance. Therefore, a girl

can turn more safely to sex to help make up for a negative self image. The promiscuity of a depressed adolescint girl is seldom sexual, in the sense of providing her erotic gratification. It serves primarily to bring her into intimate physical contact with others. The attention she recieves for her favors, the experience of feeling needed and wanted, and the sensations of being held and caressed, all may help a depressed girl overcome the feeling of being unattractive, alone, and unloved.

Another way an older adolescent may express depression is through alienation. Some depressed adolescents may withdraw from efforts to make a place for themselves in the world. Because they are so concerned about their adequacy, they tend to avoid any kind of effort that could end up in failure.

Another way an adolescent may try and find release is through suicidal behavior. Of all mental disorders, depression poses the greatest risk of actual or attempted suicide. The more depressed a person becomes, the more likely their thoughts may turn to taking their own life.[11] It is among young people who are depressed that clinicians must be the most alert to possible suicidal behavior. Adolescent suicidal behavior usually constitutes a desperate, last chance effort to get others to recognize and help them with the problems that they can't seem to find any other way to solve.

Behavior of many depressed children is similar to that of adults. Studies show that children do not outgrow depression.[12] Therefore, depression in most cases, is a lifelong illness. Some people tend to recover from severe bouts of depression within six to eighteen months and others have the lifelong susceptibility to recurring episodes of depression.[13]

When the outcome is favorable, as it is in the large

amount of young people who do not require hospitalization, providing appropriate treatment can help shorten the periods of depression and, as a result, limit the suffering experienced by the youth and his or her family. There are three forms of treatment. They are psychotherapy, environmental manipulation, and drug therapy. Depending on the severity of the disturbance, one or a combination of these methods may be used.

The main of psychotherapy treatment is to retrace and resolve the sense of loss. One advantage of psychotherapy is that, by entering the depressed adolescent's life as someone genuinely wanting to help, a therapist can reduce their feelings of being cut off from others and therefore begin to relieve depression. Another advantage is that recovery from can be shortened by helping the adolescent come to terms with the particular circumstances that are causing the experience of loss.

Another effective treatment is environmental manipulation. Psychotherapists can sometimes bring about changes in how a young person is being treated in the home, school, and community. The best avenue for constructive enviornmental manipulations is discussions with the parents of depressed adolescents. Helping parents to understand how and why their child is depressed might reduced their tension. The psychotherapist tries to convince the parents of the child's need for increased attention, affection, and reassurance. This can lead them to provide a more supportive environment. Along with the parents, the school psychologist can help in the treatment of adolescent depression. They can educate teachers to look for specific behavioral symptoms, screen those suspected of being depressed, provide referrals, and coordinate school based interventions with

other psychiatric or psychological treatments.

The use of drug therapy in the treatment of depression is a controversial issue. While some clinicians strongly advocate using antidepressant medications in treating adolescent depression, others believe that drugs are of little benefit. When medication is used in treatment, the drugs most commonly prescribed are the tricyclics. Of the tricyclics, the most frequent one chosen is imipramine, which is sold under the trade name, Trofranil.

According to data from Outpatient Psychiatric Services, only about five percent of all adolescents under the age of eighteen are diagnosed as depressed.[14] Its actual prevalence probably greatly exceed this level. The reason for this is that most adolescents who are depressed are never diagnosed or hospitalized. Some writers maintain that depressive symptoms are too common to call any professional intervention or constitute a syndrome.

ENDNOTES

[1] Graham D. Burrows, Handbook of Studies on Depression (Amsterdam, The Netherlands: Elsevier/ North-Holland Biomedical Press, 1977), p. 108.

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[6] S. J. Blatt, S. J. Wein, E. Chevron, and D. M. Quinlan, "Parental representations and depression in normal young adults," Journal of Abnormal Psychology, 88 (1979), 388.

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[10] Stuart L. Kaplan, M. Nussbaum, P. Skomorosky, I. R. Shenker, and P. Ramsey, "Health habits anddepression in adolescence," Journal of Youth and Adolescence, 9 (1980), 299-304.

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[13] J. Price, "The genetics of depressive disorder: a symposium," British Journal of Psychiatry Special Publication no. 2.

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